DEPARTMENT OF HUMAN SERVICES FATALITY REVIEW EXECUTIVE SUMMARY FY 2013 Compiled by **Department of Human Services** Office of Services Review **August 1, 2013**

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DEPARTMENT OF HUMAN ERVICES FATALITY REVIEW EXECUTIVE SUMMARY

JULY 1, 2012 - JUNE 30, 2013

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open DHS case at the time of death or in cases where the individuals or their families have received services through DHS within 12 months preceding the death. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs.

During FY 2013, 173 deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were six suicide deaths (3%) and two homicides (1%). The reviews indicate that abuse and/or neglect were contributing factors in six (3%) of the 173 deaths. One child (3%) of the 28 fatalities reported by the Division of Child and Family Services (DCFS) died as the direct result of abuse or neglect by their parents/caretakers.

Of the 28 fatalities reported by DCFS, 24 formal committee reviews were held (86%), four reviews were waived (14%), with no reviews pending. Thirty-eight of the 71 reported DSPD fatalities were reviewed (53.5%), 31 reviews were waived (46.5%), with no reviews pending. One Division of Juvenile Justice Services (DJJS) fatality was reviewed (100%). On-site reviews were held for the four reported Utah State Developmental Center (USDC) fatalities (100%). Utah State Hospital (USH) conducted an on-site review for its one reported fatality (100%).

The deaths of 57 individuals who received services through the Division of Aging and Adult Services (DAAS) were reported, with all formal committee reviews (100%) being waived. The Office of the Public Guardian (OPG) reported the deaths of 16 individuals for whom they provided services. Four of these individuals (25%) were also receiving services through DSPD at the time of death, and one individual (5%) was also receiving services through USDC. Full committee reviews were held for these five individuals. OPG provided the Fatality Review Coordinator with comprehensive written reports detailing services provided and information relating to the deaths of their 16 clients (100%).

There were 88 (51%) reported deaths of male clients and 85 (49%) reported deaths of female clients. Reported deaths included 14 infants (8%) under the age of one year; 20 individuals (11.5%) between the ages of one to 19 years; 44 individuals (25.5%) between the ages of 20 to 49 years; 39 individuals (22.5%) between the ages of 50 to 69 years; 46 individuals ((26.5%) between the ages of 70 to 89 years, and 10 individuals (6%) between the ages of 90 to 101 years.

Included in the 173 reported fatalities were two (1%) Native Americans, three (2%) Asians, three (2%) Black/African Americans, 156 (90%) Caucasians, and nine (5%) Hispanics.

DEPARTMENT OF HUMAN SERVICES DIVISION SUMMARY FY 2013

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Committee Reviews Held	Committee Reviews Waived	Reviews Pending	Male	Female
DEPARTMENT OF HUMAN SERVICES	173	147	68	105	0	88	85
DAAS (Division of Aging and Adult Services)	57	54	0	57	0	24	33
DCFS (Division of Child and Family Services)	28	8	24	4	0	17	11
DJJS (Division of Juvenile Justice Services)	1	1	1	0	0	1	0
DSPD – COMMUNITIY PLACEMENT (Division of Services for People with Disabilities)	64	62	31	33	0	35	29
DSPD/DAAS (Division of Services for People with Disabilities/Division of Adult and Aging Services)	1	0	1	0	0	0	1
DSPD/DCFS (Division of Services for People with Disabilities/Division of Child and Family Services)	1	1	1	0	0	0	1
DSPD/DSA/MH (Division of Services for People with Disabilities/Division of Substance Abuse and Mental Health)	1	1	1	0	0	0	1
DSPD/OPG (Division of Services for People with Disabilities/Office of the Public Guardian)	4	4	4	0	0	2	2
OPG (Office of the Public Guardian)	11	11	0	11	0	6	5
USDC (Utah State Developmental Center)	3	3	3	0	0	3	0
USDC/OPG Utah State Developmental Center/Office of the Public Guardian)	1	1	1	0	0	0	1
USH/DSA/MH (Utah State Hospital/(Division of Substance Abuse/Mental Health)	1	1	1	0	0	0	1

CHART I FIVE-YEAR COMPARISON FY 2009 – FY 2013

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
DHS Reported Deaths	130	159	164	177	173
DAAS	2	34	36	54	57
DCFS	49	38	53	42	28
DCFS/DSPD	3	2	0	1	1
DJJS	3	1	1	1	1
DJJS/DCFS	4	3	1	0	0
DSPD	49	61	46	59	64
DSPD/DAAS				2	1
DSPD/DSA/MH					1
DSPD/OPG			5	1	4
OPG	7	9	12	13	11
USDC	7	4	3	3	3
USDC/OPG	2	3	6	0	1
USH	4	4	1	1	1
Cases Open at Time of Death	106	111	121	155	147
Cases Reviewed	121	70	69	74	105
Abuse & Neglect Deaths	4	2	9	7	6
Accidental Deaths	12	18	24	15	8
Homicides	5	1	7	5	2
Motor Vehicle or Auto/Pedestrian Accidents	1	6	9	3	2
Suicides	7	10	8	4	6
Could Not Be Determined	9	6	3	9	5

CHART II AGE AT TIME OF DEATH

AGE IN YEARS	DHS	DAAS	DCFS	DJJS	DSPD	DSPD/ DAAS	DSPD/ DCFS	DSPD/DSA/ MH	DSPD/ OPG	OPG	USDC	USDC/ OPG	USH
< 1	14		14										
1-3	6		6										
4 - 6	0												
7 - 10	3		3										
11 - 14	2		1		1								
15 - 19	9		4	1	3		1						
20 - 29	14				13								1
30 - 39	14	1			13								
40 - 49	16	2			10				2	1	1		
50 - 59	17	2			10	1			1	1	2		
60 - 69	22	8			10			1	1	2			
70 - 79	25	16			4					4		1	
80 - 89	21	18								3			
90 – 99	9	9											
100 – 101	1	1											
TOTALS	173	57	28	1	64	1	1	1	4	11	3	1	1

CHART III ACCIDENTAL DEATHS FY 2013

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Asphyxia	2			
Choking		Female	56	DSPD
Strangulation		Male	10	DCFS
Fall	4			
		Female	10	DCFS
		Female	60	DSPD/DSA/MH
		Female	75	DAAS
		Female	79	DAAS
Motor Vehicle Accident	2			
		Female	3	DCFS
		Male	39	DAAS
TOTAL	8			

CHART IV HOMICIDE DEATHS FY 2013

MANNER OF HOMICIDE	DHS	GENDER	AGE	DIVISION
Gunshot	1			
		Male	17	DJJS
Blunt Force Injuries (Inflicted)	1			
		Male	3 months	DCFS
TOTAL	2			

CHART V SUICIDE DEATHS FY 2013

MANNER OF SUICIDE	DHS	GENDER	AGE	DIVISION
Asphyxia (Hanging)	4			
		Female	15	DCFS
		Female	15	DCFS
		Male	17	DCFS
		Female	29	USH
Drug Toxicity	1			
		Female	16	DCFS
Gunshot Wound	1			
		Male	81	DAAS
TOTAL	6			

CHART VI ABUSE/NEGLECT DEATHS FY 2013

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Choking	1			
		Female	56	DSPD
Fall	1			
		Female	60	DSPD/DSA/MH
		Female	79	DAAS
Physical Abuse	3			
		Male	3 months	DCFS
Sepsis	1			
		Female	77	DAAS
TOTAL	6			

CHART VII MEDICAL EXAMINER'S DETERMINATION MANNER OF DEATH FY 2013

MANNER OF DEATH	DHS	DAAS	DCFS	DJJS	DSPD	DSPD/ DAAS	DSPD/ DCFS	DSPD/ OPG	OPG	USDC	USH
Accident	8	3	3		2						
Homicide	2		1	1							
Natural Causes	152	53	15		63	1	1	4	11	4	
Suicide	6	1	4								1
Could Not Be Determined	5		5								
TOTALS	173	57	28	1	65	1	1	4	11	4	1

CHART VIII DECEDENTS' RACE FY 2013

RACE	DHS	DAAS	DCFS	DJJS	DSPD	DSPD/ DAAS	DSPD/ DCFS	DSPD/ DSA/ MH	DSPD/ OPG	OPG	USDC	USDC/ OPG	USH
AMERICAN INDIAN													
Navajo	1	1											
Shawnee	1		1										
ASIAN													
Bhutanese	1	1											
Korean	1									1			
Laotian	1	1											
BLACK/AFRICAN AMERICAN	3			1	1					1			
CAUCASIAN	156	53	22		60	1	1	1	4	9	3	1	1
HISPANIC													
Mexican	8	1	5		2								
Puerto Rican	1				1								
TOTALS	173	57	28	1	64	1	1	1	4	11	3	1	1

CHART IX FATALITIES BY REGION AND OFFICE FY 2013

DIVISION OF AGING AND ADULT SERVICES

REGION	TOTAL
Central	25
Northern	6
Southern	26
TOTAL	57

DIVISION OF CHILD AND FAMILY SERVICES

REGION	TOTAL
Eastern	2
Northern	13
Salt Lake Valley	7
Southwest	1
Western	5
TOTAL	28

DIVISION OF JUVENILE JUSTICE SERVICES

REGION	TOTAL
Region III	1
TOTAL	1

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

COMMUNITY BASED and UTAH STATE DEVELOPMENTAL CENTER (USDC)

REGION	TOTAL
Central	29
Northern	14
Southern	28
USDC	3
USDC/OPG	1
TOTAL	75

OFFICE OF THE PUBLIC GUARDIAN

REGION	TOTAL
Central	
OPG	11
OPG/DSPD	4
OPG/USDC	1
TOTAL	16

DIVISION OF SUBSTANCE ABUSE/MENTAL HEALTH UTAH STATE HOSPITAL

REGION	TOTAL
USH	1
TOTAL	1